

**Island Smiles**  
**Guy L. Chisteckoff DDS**

**Office Financial Policies and Federal Truth in Lending Statement**

As a condition of treatment in this office, financial arrangements must be made in advance.

I understand that all emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Although dental insurance may be applicable, I understand that all services furnished are charged directly to the responsible party listed on this form and that he/she is personally responsible for payment. As a courtesy, Guy L. Chisteckoff, DDS office staff will assist in the preparation of any and all dental insurance forms. Guy L. Chisteckoff, DDS cannot render services on the assumption that all charges to the patient will be paid in full by an insurance company.

A service charge of 1 1/2 % per month (18 per annum) on any unpaid balance will be assessed beginning sixty days from the date of service.

Any estimate listed for dental care can only be extended for a period of 90 days from the date of the written estimate.

In consideration for the professional services rendered to me or any minor child or ward by Guy L. Chisteckoff, DDS, I agree to pay the reasonable value of said services to Guy L. Chisteckoff DDS or assignee at the time said services are rendered, or within 30 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder, to collect monies owed by me, including charges or commissions up to 50% that may be assessed to Guy L. Chisteckoff DDS or by any collection agency retained to pursue this matter.

I grant my permission to Guy L. Chisteckoff DDS or assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member. I authorize assignment or payment of all dental and/or surgical benefits to which I, or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned to Guy L. Chisteckoff DDS.

**I certify that I have read and understand this form. I hereby                      to abide by the conditions outlined hereon.**

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date

**I certify that I have read and understand this form. I hereby disagree with the statements above. I will continue as a patient and prepay all treatment upfront and in full.**

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Date